

CHAPTER 37
MEDICARE SUPPLEMENT INSURANCE

191—37.1(514D) Purpose and authority. The purpose of this chapter is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare. This chapter is issued pursuant to the authority vested in the commissioner under Iowa Code chapter 514D.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.2(514D) Applicability, scope, and appendices.

37.2(1) *Applicability and scope.*

a. Except as otherwise specifically provided in rules 191—37.6(514D), 191—37.22(514D), 191—37.23(514D), 191—37.28(514D) and 191—37.32(514D), this chapter shall apply to:

(1) All Medicare supplement individual or group policies delivered or issued for delivery in this state on or after May 15, 2019, unless otherwise stated; and

(2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state on or after May 15, 2019, unless otherwise stated.

b. This chapter shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof; for employees or former employees, or a combination thereof; or for members or former members, or a combination thereof, of the labor organizations.

37.2(2) *Appendices.* The following appendices can be found at the end of this chapter:

a. Appendix A: Medicare Supplement Refund Calculation Form. This form is to be completed pursuant to subrule 37.23(3).

b. Appendix B: Disclosure Statements. The applicable notice from the choices in Appendix B shall be used on Medicare supplement applications, pursuant to subrule 37.26(2).

c. Appendix C: Statements and Questions for Application Forms Related to Duplicate or Replacement Coverage. The statements and questions in Appendix C shall be included with the outline of coverage and delivered with any application form for Medicare supplement policies or certificates to an applicant, as required by subrules 37.27(1) and 37.27(2).

d. Appendix D: Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage. The notice form of Appendix D shall be provided as required by subrules 37.27(4) and 37.27(5).

e. Appendix E: Outline of Coverage: Benefit Charts. The items in the applicable tables in this Appendix E, displaying the features of each benefit plan offered by the issuer, shall be included in the outline of coverage in the order prescribed, pursuant to subrule 37.28(4).

f. Appendix F: Form for Reporting Medicare Supplement Policies or Certificates. This form is to be completed pursuant to subrule 37.32(1).

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191—37.3(514D) Definitions. For purposes of this chapter, in addition to the definitions in Iowa Code section 514D.2, the following definitions shall apply, unless otherwise specified:

“1990 standardized Medicare supplement benefit plan” or “1990 plan” means a group or individual Medicare supplement policy issued on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after June 1, 2010, which are not replaced by the issuer at the request of the insured.

“2010 standardized Medicare supplement benefit plan” or “2010 plan” means a group or individual Medicare supplement policy issued with an effective date for coverage on or after June 1, 2010.

“Applicant” means:

1. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare supplement policy, the proposed covered individual, unless stated otherwise.

“*Basic core benefits*” are benefits defined in subrule 37.7(2) for 1990 plans, subrule 37.8(2) for 2010 plans, and subrule 37.9(1) for Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020.

“*Certificate*” means any certificate of coverage delivered or issued for delivery in this state to a covered individual under a group Medicare supplement policy.

“*Certificate form*” means the form (as defined in Iowa Code section 514D.2(2)) on which the certificate is delivered or issued for delivery by the issuer.

“*Certificate holder*” means the named individual to whom the certificate of coverage under a group policy is issued, or a spouse, if applicable.

“*CMS*” means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

“*Commissioner*” means the Iowa insurance commissioner, and includes the insurance division as delegated.

“*Covered individual*” means an individual who may receive benefits under an individual or group Medicare supplement policy because the individual is one of the following: the named insured under an individual Medicare supplement policy; the named certificate holder under a group Medicare supplement policy; or an individual such as a spouse covered by way of the named certificate holder’s group Medicare supplement policy. For purposes of rule 191—37.20(514D), “covered individual” means an individual who may receive benefits under an individual or group Medicare Select policy because the individual is one of the following: the named insured under an individual Medicare Select policy; the named certificate holder under a group Medicare Select policy; or an individual such as a spouse covered by way of the named certificate holder’s group Medicare Select policy.

“*Creditable coverage.*”

1. “Creditable coverage” means, with respect to an individual, health coverage of the individual provided under any of the following:

- A group health plan;
- Health insurance coverage;
- Part A or Part B of Title XVIII of the Social Security Act (Medicare);
- Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
- Chapter 55 of Title 10, United States Code (CHAMPUS);
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health benefits risk pool;
- A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program);

- A public health plan as defined in federal regulation; and
- A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

2. “Creditable coverage” shall not include one or more of, or any combination of, the following:

- Coverage only for accident or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers’ compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics; and
- Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

3. “Creditable coverage” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

- Limited scope dental or vision benefits;
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
- Such other similar limited benefits as are specified in federal regulations.

4. “Creditable coverage” shall not include the following benefits if offered as independent, noncoordinated benefits:

- Coverage only for a specified disease or illness; and
- Hospital indemnity or other fixed indemnity insurance.

5. “Creditable coverage” shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

- Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
- Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and
- Similar supplemental coverage provided to the coverage under a group health plan.

“File” or “filing,” when used in reference to filing information with the commissioner or with the insurance division, means submitting information as set forth in these rules through the System for Electronic Rate and Form Filing (SERFF), www.serff.com, or as otherwise directed by the insurance division through its website, iid.iowa.gov.

“Group member” means the individual who is a member of the group entity to which the group policy is issued.

“Group policyholder” means the group entity to which a group Medicare supplement policy is issued.

“Insolvency” means that an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer’s state of domicile.

“Insurance division” means the Iowa insurance division.

“Issuer” includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

“Medicare” means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

“Medicare Advantage plan” means a plan of coverage for health benefits under Medicare Part C (as defined in 42 U.S.C. 1395w-28(b)(1)), and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;
2. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and
3. Medicare Advantage private fee-for-service plans.

“Medicare Select policy,” “Medicare Select certificate,” “Medicare Select issuer,” and “Medicare Select network provider” are defined in subrule 37.20(2).

“Medicare supplement policy” means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. “Medicare supplement policy” does not include Medicare Advantage plans, outpatient

prescription drug plans established under Medicare Part D, or any health care prepayment plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

“*MMA*” means the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

“*PACE program*” means a program of all-inclusive care for the elderly, operated by an approved PACE organization (an entity that is approved as a PACE program by the Iowa department of human services and that has in effect a PACE program agreement between the entity, CMS, and the Iowa department of human services to operate a PACE program) that provides comprehensive health care services to enrollees in Iowa, pursuant to Section 1894 of the Social Security Act (42 U.S.C. 1395eee) and Iowa Administrative Code rules 441—88.21(249A) through 441—88.28(249A).

“*Person*” means any individual, corporation, association, or partnership.

“*Policy form*” means the form (as defined by Iowa Code section 514D.2(2)) on which the policy (as defined by Iowa Code section 514D.2(4)) is delivered or issued for delivery by the issuer.

“*Policyholder*” means the individual person to whom or group entity to which an individual or group Medicare supplement policy is issued.

“*PPS*” means prospective payment system.

“*Prestandardized Medicare supplement benefit plan*” or “*prestandardized plan*” means a group or individual Medicare supplement policy issued prior to January 1, 1992.

“*Producer*” means a person licensed in this state pursuant to Iowa Code chapter 522B and Iowa Administrative Code 191—Chapter 10 to sell, solicit, negotiate, effect, procure, deliver, renew, continue or bind policies of insurance for persons residing or located, or for policies to be performed, in this state.

“*Secretary*” means the Secretary of the U.S. Department of Health and Human Services.

“*SMSBP*” or “*standardized Medicare supplement benefit plan*” means a 1990 plan, a 2010 plan, or a plan described in subrule 37.9(1) for Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020.

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191—37.4(514D) Policy definitions and terms. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this rule.

“*Accident*,” “*accidental injury*,” or “*accidental means*” shall be defined to employ “result” language and shall not include words which establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization.

1. The definition shall not be more restrictive than the following: “Injury or injuries for which benefits are provided means accidental bodily injury sustained by the covered individual which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.”

2. Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers’ compensation, employer’s liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

“*Benefit period*” or “*Medicare benefit period*” shall not be defined more restrictively than as defined by Medicare.

“*Convalescent nursing home*,” “*extended care facility*,” or “*skilled nursing facility*” shall not be defined more restrictively than as defined by Medicare.

“*Hospital*” may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined by Medicare.

“*Medicare*” shall be defined in the policy and certificate. Medicare may be substantially defined as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended,” or “Title I, Part I of Pub. L. No. 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import.

“*Medicare-eligible expenses*” shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

“*Physician*” shall not be defined more restrictively than as defined by Medicare.

“*Sickness*” shall not be defined to be more restrictive than the following: “Sickness means illness or disease of a covered individual which first manifests itself after the effective date of insurance and while the insurance is in force.” The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers’ compensation, occupational disease, employer’s liability or similar law.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.5(514D) Policy provisions.

37.5(1) Coverage restrictions related to Medicare. Except for permitted preexisting condition clauses as described in paragraphs 37.6(1) “a,” 37.7(1) “d,” and 37.8(1) “d,” no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate if such Medicare supplement policy or certificate contains limitations or exclusions on coverage that are more restrictive than those permitted by Medicare.

37.5(2) Waivers of preexisting conditions. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

37.5(3) Duplicate benefits. No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare insurance.

37.5(4) Renewal of pre-2006 coverage. Subject to paragraphs 37.6(1) “d,” “e,” and “g” and 37.7(1) “d” and “e,” a Medicare supplement policy or certificate with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall, at the option of a currently covered individual who does not enroll in Medicare Part D, be renewed for that covered individual.

37.5(5) Coverage of prescription drugs after 2005. A Medicare supplement policy or certificate with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

37.5(6) Renewal of coverage of prescription drugs after 2005 for enrollees of Part D. After December 31, 2005, a Medicare supplement policy or certificate with benefits for outpatient prescription drugs may not be renewed after the covered individual enrolls in Medicare Part D unless:

a. The policy or certificate is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the covered individual’s coverage under a Medicare Part D plan; and

b. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.6(514D) Minimum benefit standards for prestandardized Medicare supplement benefit plan policies or certificates issued for delivery prior to January 1, 1992 (prestandardized plans). No policy or certificate may be advertised, solicited or issued for delivery in this state as a prestandardized plan policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

37.6(1) General standards. The following standards apply to prestandardized plans and are in addition to all other requirements of this chapter.

a. A prestandardized plan shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The prestandardized plan shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

b. A prestandardized plan shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A prestandardized plan shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

d. A “noncancelable,” “guaranteed renewable,” or “noncancelable and guaranteed renewable” prestandardized plan shall not:

(1) Provide for termination of coverage of a spouse of a group member solely because of the occurrence of an event specified for termination of coverage of the group member, other than the nonpayment of premium; or

(2) Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

e. Except as authorized by the commissioner, an issuer shall neither cancel nor nonrenew a prestandardized plan policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

f. Group Medicare supplement policies.

(1) If a group prestandardized plan is terminated by the group policyholder and not replaced as provided in subparagraph 37.6(1)“f”(3), the issuer shall offer to each of the covered individuals under the group prestandardized plan an individual Medicare supplement policy. The issuer shall offer each of the group prestandardized plan’s covered individuals at least the following choices:

1. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group prestandardized plan; and

2. An individual Medicare supplement policy which provides only such benefits as are required to meet the basic core benefits minimum standards as defined in subrule 37.7(2).

(2) If a covered individual’s membership with the group entity that is the group policyholder is terminated, the issuer shall:

1. Offer the covered individual such conversion opportunities as are described in subparagraph 37.6(1)“f”(1); or

2. At the option of the group policyholder, offer the covered individual continuation of coverage under the group prestandardized plan.

(3) If a group prestandardized plan is replaced by another group Medicare supplement policy purchased by the same group policyholder, the issuer of the replacement group Medicare supplement policy shall offer coverage to all covered individuals under the replaced group prestandardized plan on its date of termination. Coverage under the new replacement group Medicare supplement policy shall not result in any exclusion for preexisting conditions that would have been covered under the replaced group prestandardized plan.

(4) If a prestandardized plan eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subrule.

g. Termination of a prestandardized plan policy or certificate shall be without prejudice to any continuous loss which commenced while the prestandardized plan policy or certificate was in force, but the extension of benefits beyond the period during which the prestandardized plan policy or certificate was in force may be predicated upon the continuous total disability of the covered individual, limited to the duration of the prestandardized plan policy or certificate benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

37.6(2) Minimum benefit standards. The following are minimum benefit standards for prestandardized plans:

a. Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

c. Coverage of Part A Medicare-eligible expenses which are incurred as daily hospital charges during the covered individual’s use of Medicare’s lifetime hospital inpatient reserve days;

d. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

e. Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

f. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a PPS, the copayment amount, of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible;

g. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.7(514D) Benefit standards for 1990 standardized Medicare supplement benefit plan policies or certificates issued for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010 (1990 plans). The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any prestandardized Medicare supplement benefit plan for sale on or after January 1, 1992. Benefit standards applicable to Medicare supplement policies and certificates issued before January 1, 1992, remain subject to the requirements of rule 191—37.6(514D).

37.7(1) General standards. The following standards apply to 1990 plans and are in addition to all other requirements of this chapter.

a. *Combinations of benefits other than standard not allowed.* No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in subrule 37.7(6) and in rule 191—37.20(514D).

b. *Uniformity and conformity.* All 1990 plans shall be uniform in structure, language, designation and format to the standardized Medicare supplement benefit plans A through L listed in subrule 37.7(4) and shall conform to the definitions in rules 191—37.3(514D) and 191—37.4(514D). Each benefit shall be structured in accordance with the format provided in this rule and list the benefits in the order shown in this rule. For purposes of this rule, “structure, language, and format” means style, arrangement and overall content of a benefit.

c. *Other designations may be used.* An issuer may use, in addition to the benefit plan designations required in paragraph 37.7(1)“b,” other designations to the extent permitted by law.

d. *Preexisting conditions.* A 1990 plan shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because the claim involved a preexisting condition. The 1990 plan may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

e. *Sickness same as accident.* A 1990 plan shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

f. *Automatic change of cost sharing.* A 1990 plan shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable deductible, copayment, or coinsurance amounts set by Medicare. Premiums may be modified to correspond with such changes.

g. Termination of coverage of spouse. No 1990 plan shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

h. Guaranteed renewability. Each 1990 plan shall be guaranteed renewable.

(1) The issuer shall not cancel or nonrenew a 1990 plan solely on the ground of health status of the covered individual.

(2) The issuer shall not cancel or nonrenew a 1990 plan for any reason other than nonpayment of premium or material misrepresentation.

(3) If the 1990 plan is terminated by the group policyholder and is not replaced as provided under subparagraph 37.7(1) "h"(5), the issuer shall offer to the covered individual a conversion opportunity of an individual Medicare supplement policy which, at the option of the covered individual, either:

1. Provides for continuation of the benefits contained in the group 1990 plan; or
2. Provides for such benefits as otherwise meet the requirements of this subrule.

(4) If a covered individual under a group 1990 plan terminates membership in the group, the issuer shall either:

1. Offer the covered individual the conversion opportunity described in subparagraph 37.7(1) "h"(3); or

2. At the option of the group policyholder, offer the covered individual continuation of coverage under the group Medicare supplement policy.

(5) If a group 1990 plan is replaced by another group Medicare supplement policy purchased by the same group policyholder, the issuer of the replacement group Medicare supplement policy shall offer coverage under the replacement group Medicare supplement policy to all covered individuals of the replaced group 1990 plan effective on the date of termination of the replaced group 1990 plan. Coverage under the replacement group Medicare supplement policy shall not result in any exclusion of any covered individual's preexisting conditions that would have been covered under the replaced group 1990 plan.

(6) If a 1990 plan eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified 1990 plan shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

i. Termination involving continuous loss. Termination of a 1990 plan shall be without prejudice to any continuous loss which commenced while the 1990 plan was in force, but the extension of benefits beyond the period during which the 1990 plan was in force may be conditioned upon the continuous total disability of the covered individual, limited to the duration of the 1990 plan benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

j. Suspension for Title XIX coverage.

(1) A 1990 plan shall provide that benefits and premiums under the 1990 plan shall be suspended at the request of the covered individual for the period (not to exceed 24 months) in which the covered individual has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the covered individual notifies the issuer of such 1990 plan within 90 days after the date the covered individual becomes entitled to such assistance.

(2) If such suspension occurs and if the covered individual loses entitlement to such medical assistance, such 1990 plan shall be automatically reinstated (effective as of the date of termination of such entitlement) if the covered individual provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(3) Each 1990 plan shall provide that benefits and premiums under the 1990 plan shall be suspended for the period provided by federal regulation at the request of the covered individual if the covered individual is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the covered individual loses coverage under the group health plan, the 1990 plan shall be automatically reinstated effective as of the date of loss of coverage if the covered individual provides

notice to the issuer of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(4) Reinstitution of coverage as described in subparagraphs 37.7(1) “j”(2) and (3):

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended 1990 plan provided coverage for outpatient prescription drugs, reinstatement of the 1990 plan for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

3. Shall provide for classification of premiums on terms at least as favorable to the covered individual as the premium classification terms that would have applied to the covered individual had the coverage not been suspended.

k. Exchange of 1990 plan to 2010 plan. If an issuer makes a written offer to a covered individual covered by one or more of the issuer’s 1990 plans (as described in this rule) to allow, during a specified period, the covered individual to exchange coverage from the covered individual’s 1990 plan (as described in this rule) to a 2010 plan (as described in rule 191—37.8(514D)), the offer and subsequent exchange shall comply with the following requirements:

(1) An issuer need not provide justification to the commissioner or comply with 191—Chapter 16 or rule 191—37.27(514D) if the covered individual exchanges a 1990 plan policy or certificate for an issue-age-rated 2010 plan policy or certificate using the same issue age and duration as was used for the covered individual’s 1990 plan policy or certificate to be exchanged. If a covered individual’s 1990 plan policy or certificate to be exchanged is priced on an issue-age-rate schedule at the time of such offer, the rate charged to the covered individual for the exchanged 2010 plan policy or certificate shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue-age-rate basis, for the benefit of the covered individual. The rating method proposed to be used by an issuer must be filed with the commissioner pursuant to rule 191—37.24(514D).

(2) The rating class of the new exchanged 2010 plan policy or certificate shall be the class closest to the covered individual’s rating class of the exchanged 1990 plan.

(3) An issuer may not apply new preexisting condition limitations or a new incontestability period to the covered individual’s exchanged 2010 plan for those benefits contained in the exchanged 1990 plan, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the exchanged 2010 plan that were not contained in the exchanged 1990 plan.

(4) The exchanged 2010 plan shall be offered to all covered individuals within a given 1990 plan, except where the offer or issue would be in violation of state or federal law.

37.7(2) Standards for basic core benefits common to 1990 standardized Medicare supplement benefit plans A through J (1990 plans). Every issuer shall make available a 1990 plan including only the following basic core benefits to each prospective covered individual. An issuer may make available to prospective covered individuals any of the issuer’s other standardized Medicare supplement benefit plans in addition to the basic core benefits, but not in lieu thereof. The 1990 basic core benefits are the following:

a. Coverage of Part A Medicare-eligible expenses for hospitalization, to the extent not covered by Medicare, from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage of Part A Medicare-eligible expenses incurred for hospitalization, to the extent not covered by Medicare, for each Medicare lifetime inpatient reserve day used;

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization, paid at the applicable PPS rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Medicare requires that the provider shall accept the issuer’s payment as payment in full and that the provider may not bill the covered individual for any balance;

d. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

e. Coverage for the coinsurance amount or, in the case of hospital outpatient department services paid under a PPS, the copayment amount of Medicare Part B eligible expenses regardless of hospital confinement, subject to the Medicare Part B deductible.

37.7(3) Standards for additional benefits for plans B through J. The following benefit descriptions apply to the additional benefits specified for 1990 plans B through J in subrule 37.7(4):

a. Medicare Part A deductible: coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

b. Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

c. Medicare Part B deductible: coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

d. Eighty percent of the Medicare Part B excess charges: coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by Medicare or by state law, and the Medicare-approved Part B charge.

e. One hundred percent of the Medicare Part B excess charges: coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by Medicare or by state law, and the Medicare-approved Part B charge.

f. Basic outpatient prescription drug benefit: coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the covered individual per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare 1990 plan until January 1, 2006.

g. Extended outpatient prescription drug benefit: coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the covered individual per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare 1990 plan until January 1, 2006.

h. Medically necessary emergency care in a foreign country: coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. Preventive medical care benefit:

(1) Coverage for the following preventive health services not covered by Medicare:

1. An annual clinical preventive medical history and physical examination that may include tests and services from numbered paragraph “2” and patient education to address preventive health care measures.

2. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(2) Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

j. At-home recovery benefit: coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(1) For purposes of this benefit, the following definitions shall apply:

“*Activities of daily living*” includes, but is not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

“*At-home recovery visit*” means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

“*Care provider*” means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

“*Home*” shall mean any place used by the covered individual as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the covered individual’s place of residence.

(2) Coverage requirements and limitations.

1. At-home recovery services provided must be primarily services which assist in activities of daily living.

2. The covered individual’s attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

3. Coverage is limited to:

- No more than the number and type of at-home recovery visits certified as necessary by the covered individual’s attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.

- The actual charges for each visit up to a maximum reimbursement of \$40 per visit.

- One thousand six hundred dollars per calendar year.

- Seven visits in any one week.

- Care furnished on a visiting basis in the covered individual’s home.

- Services provided by a care provider as defined in this paragraph 37.7(3) “j.”

- At-home recovery visits while the covered individual is covered under the policy or certificate and not otherwise excluded.

- At-home recovery visits received during the period the covered individual is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(3) Coverage is excluded for:

1. Home care visits paid for by Medicare or other government programs; and

2. Care provided by family members, unpaid volunteers or providers who are not care providers.

37.7(4) Elements required in standardized 1990 Medicare supplement benefit plans. The additional benefits described in subrule 37.7(3) shall be included in 1990 Medicare supplement benefit plans as specified for each 1990 plan as follows:

a. Plan A shall be limited to the basic core benefits, as defined in subrule 37.7(2).

b. Plan B shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible as defined in paragraph 37.7(3) “a.”

c. Plan C shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs 37.7(3) “a,” “b,” “c,” and “h,” respectively.

d. Plan D shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs 37.7(3) “a,” “b,” “h,” and “j,” respectively.

e. Plan E shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in paragraphs 37.7(3) “a,” “b,” “h,” and “i,” respectively.

f. Plan F shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.7(3) “a,” “b,” “c,” “e,” and “h,” respectively.

g. Plan G shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, 80 percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs 37.7(3) “a,” “b,” “d,” “h,” and “j,” respectively.

h. Plan H shall consist of only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in paragraphs 37.7(3) “a,” “b,” “f,” and “h,” respectively. The outpatient prescription drug benefit shall not be included in a 1990 plan sold after December 31, 2005.

i. Plan I shall consist of only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in paragraphs 37.7(3) “a,” “b,” “e,” “f,” “h,” and “j,” respectively. The outpatient prescription drug benefit shall not be included in a 1990 plan sold after December 31, 2005.

j. Plan J shall consist of only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in paragraphs 37.7(3) “a,” “b,” “c,” “e,” “g,” “h,” “i,” and “j,” respectively. The outpatient prescription drug benefit shall not be included in a 1990 plan sold after December 31, 2005.

k. High deductible Plan F shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible Plan F deductible. The covered expenses include the basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.7(3) “a,” “b,” “c,” “e,” and “h,” respectively. The annual high deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be \$1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

l. High deductible Plan J shall consist of only the following: 100 percent of covered expenses following the payment of the annual high deductible Plan J deductible. The covered expenses include the basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit, and at-home recovery benefit as defined in paragraphs 37.7(3) “a,” “b,” “c,” “e,” “g,” “h,” “i,” and “j,” respectively. The annual high deductible Plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. The outpatient prescription drug benefit shall not be included in a 1990 plan sold after December 31, 2005.

m. Plan K shall consist of the following:

(1) Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first day through the ninetieth day in any Medicare benefit period;

(2) Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first day through the one hundred fiftieth day in any Medicare benefit period;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment in full and may not bill the covered individual for any balance;

(4) Medicare Part A deductible: coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 37.7(4) "m"(10);

(5) Skilled nursing facility care: coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 37.7(4) "m"(10);

(6) Hospice care: coverage for 50 percent of cost sharing for all Part A Medicare-eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 37.7(4) "m"(10);

(7) Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph 37.7(4) "m"(10);

(8) Except for coverage provided in subparagraph 37.7(4) "m"(9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the covered individual pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 37.7(4) "m"(10);

(9) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the covered individual pays the Part B deductible; and

(10) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

n. Plan L shall consist of the following:

(1) The benefits described in subparagraphs 37.7(4) "m"(1), (2), (3), and (9);

(2) The benefits described in subparagraphs 37.7(4) "m"(4), (5), (6), (7) and (8), but substituting 75 percent for 50 percent in each subparagraph; and

(3) The benefit described in paragraph 37.7(4) "m"(10), but substituting \$2,000 for \$4,000.

37.7(5) *Elements required in Medicare supplement plans mandated by the MMA.* The 1990 plans mandated by the MMA, Plans K and L, shall include the benefits described for each plan, as follows:

a. Plan K mandated by the MMA shall consist of only those benefits described in paragraph 37.7(4) "m."

b. Plan L mandated by the MMA shall consist of only those benefits described in paragraph 37.7(4) "n."

37.7(6) *New or innovative benefits.* An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.8(514D) Benefit standards for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010 (2010 plans). The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate was to be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate during that time period unless it complied with the benefit standards set forth in this rule. No issuer may offer any 1990 standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of rule 191—37.6(514D) or 191—37.7(514D).

37.8(1) General standards. The following standards apply to 2010 plans and are in addition to all other requirements of this chapter.

a. Combinations of benefits other than standard not allowed. No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in subrule 37.8(5) and rule 191—37.20(514D).

b. Uniformity and conformity. All 2010 plans shall be uniform in structure, language, designation and format to the standardized benefit plans listed in subrule 37.8(4), and shall conform to the definitions in rules 191—37.3(514D) and 191—37.4(514D). Each benefit plan shall be structured in accordance with the format provided in subrules 37.8(2), 37.8(3) and 37.8(4), or in the case of Plan K or L, each benefit plan shall be structured in accordance with the format provided in paragraph 37.8(4)“h” or “i.” Each plan shall list the benefits in the order shown. For purposes of this rule, “structure, language, and format” means style, arrangement and overall content of a benefit.

c. Other designations may be used. An issuer may use, in addition to the benefit plan designations required in paragraph 37.8(1)“b,” other designations to the extent permitted by law.

d. Preexisting conditions. A 2010 plan shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because the losses involved a preexisting condition. The 2010 plan may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

e. Sickness same as accident. A 2010 plan shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

f. Automatic change of cost sharing. A 2010 plan shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

g. Termination of coverage of spouse. No 2010 plan shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the named insured or group member, other than the nonpayment of premium.

h. Guaranteed renewability. Each 2010 plan shall be guaranteed renewable.

(1) The issuer shall not cancel or nonrenew the policy or certificate solely on the ground of health status of the covered individual.

(2) The issuer shall not cancel or nonrenew the 2010 plan for any reason other than nonpayment of premium or material misrepresentation.

(3) If a group 2010 plan is terminated by the group policyholder and is not replaced as provided under subparagraph 37.8(1)“h”(5), the issuer shall offer covered individuals a conversion opportunity to an individual 2010 plan which, at the option of the covered individual, either:

1. Provides for continuation of the benefits contained in the group 2010 plan; or
2. Provides for benefits that otherwise meet the requirements of this subrule.

(4) If a covered individual under a group 2010 plan terminates membership in the group, the issuer shall:

1. Offer the covered individual the conversion opportunity described in subparagraph 37.8(1)“h”(3); or

2. At the option of the group policyholder, offer the covered individual continuation of coverage under the group 2010 plan.

(5) If a group 2010 plan is replaced by another group Medicare supplement policy purchased by the same group policyholder, the issuer of the replacement group Medicare supplement policy shall offer coverage under the replacement group Medicare supplement policy to all covered individuals of the replaced group 2010 plan on the effective date of termination of the replaced group 2010 plan. Coverage under the replacement group Medicare supplement policy shall not result in any exclusion for any covered individual's preexisting conditions that would have been covered under the replaced group 2010 plan.

i. Termination involving continuous loss. Termination of a 2010 plan policy or certificate shall be without prejudice to any continuous loss which commenced while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy or certificate was in force may be conditioned upon the continuous total disability of the covered individual, limited to the duration of the policy or certificate benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

j. Suspension for Title XIX coverage.

(1) A 2010 plan shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the covered individual for the period (not to exceed 24 months) in which the covered individual has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the covered individual notifies the issuer of the policy or certificate within 90 days after the date the covered individual becomes entitled to assistance.

(2) If such suspension occurs and if the covered individual loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated effective as of the date of termination of entitlement if the covered individual provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(3) Each 2010 plan shall provide that benefits and premiums under the 2010 plan shall be suspended (for any period that may be provided by federal regulation) at the request of the covered individual if the covered individual is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the covered individual loses coverage under the group health plan, the 2010 plan policy or certificate shall be automatically reinstated effective as of the date of loss of coverage if the covered individual provides notice to the issuer of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(4) Reinstitution of coverage as described in subparagraphs 37.8(1) "j"(2) and (3):

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

3. Shall provide for classification of premiums on terms at least as favorable to the covered individual as the premium classification terms that would have applied to the covered individual had the coverage not been suspended.

37.8(2) Standards for basic core benefits common to 2010 standardized Medicare supplement benefit Plans A, B, C, D, F, F with high deductible, G, M, and N (2010 basic core benefits).

a. Availability of basic core benefits required. Every issuer of 2010 plans shall make available to each prospective covered individual a 2010 plan including only the following 2010 basic core benefits. An issuer may make available to a prospective covered individual any of the issuer's other Medicare supplement benefit plans in addition to the 2010 plan of basic core benefits, but not in lieu thereof.

b. When issuer must make certain plans available. If an issuer makes available any of the additional benefits described in subrule 37.8(3) or offers standardized benefit Plans K or L (as described in paragraphs 37.8(4) "h" and "i"), then the issuer shall make available to each prospective covered individual, in addition to a policy form or certificate form with only the 2010 plan basic core benefits as set forth in paragraph 37.8(2) "c," a policy form or certificate form containing either standardized

benefit Plan C (as described in paragraph 37.8(4)“c”) or a standardized benefit Plan F (as described in paragraph 37.8(4)“e”).

c. 2010 plan basic core benefits. The 2010 plan basic core benefits shall include the following:

(1) Hospitalization days 61 through 90: coverage of Part A Medicare-eligible expenses for hospitalization, to the extent not covered by Medicare, from the sixty-first day through the ninetieth day in any Medicare benefit period;

(2) Hospitalization for reserve days: coverage of Part A Medicare-eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Hospitalization for additional 365 days: upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Medicare requires that the provider shall accept the issuer’s payment as payment in full and that the provider may not bill the covered individual for any balance;

(4) Blood: coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coinsurance: coverage for the coinsurance amount or, in the case of hospital outpatient department services paid under a PPS, the copayment amount of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible; and

(6) Hospice care: coverage of cost sharing for all Part A Medicare-eligible hospice care and respite care expenses.

37.8(3) Standards for 2010 plan additional benefits. The following additional benefits shall be included in 2010 plan Plans B, C, D, F, F with high deductible, G, M, and N as provided by subrule 37.8(4):

a. Medicare Part A deductible: coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

b. Medicare Part A deductible: coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

c. Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

d. Medicare Part B deductible: coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

e. One hundred percent of the Medicare Part B excess charges: coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge; and

f. Medically necessary emergency care in a foreign country: coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

37.8(4) Elements required in standardized 2010 Medicare supplement benefit plans. The 2010 plans shall include the benefits, as described for each plan, as follows:

a. Plan A shall include only the following: the basic core benefits as set forth in subrule 37.8(2).

b. Plan B shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible as defined in paragraph 37.8(3)“a.”

c. Plan C shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the

Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) "a," "c," "d," and "f," respectively.

d. Plan D shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) "a," "c," and "f," respectively.

e. Plan F shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) "a," "c," "d," "e," and "f," respectively.

f. Plan F with high deductible.

(1) Plan F with high deductible shall include only the following:

1. One hundred percent of covered expenses following the payment of the annual deductible set forth in subparagraph 37.8(4) "f"(2).

2. The basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) "a," "c," "d," "e," and "f," respectively.

(2) The annual deductible in Plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by (regular) Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

g. Plan G shall include only the following: the core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) "a," "c," "e," and "f," respectively.

h. Plan K is mandated by the MMA and shall include only the following:

(1) Medicare Part A hospital coinsurance from the sixty-first day through the ninetieth day: coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first day through the ninetieth day in any Medicare benefit period;

(2) Medicare Part A hospital coinsurance from the ninety-first day through the one hundred fiftieth day: coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first day through the one hundred fiftieth day in any Medicare benefit period;

(3) Medicare Part A hospitalization after lifetime reserve days are exhausted: upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the covered individual for any balance;

(4) Medicare Part A deductible: coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 37.8(4) "h"(10);

(5) Skilled nursing facility care: coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 37.8(4) "h"(10);

(6) Hospice care: coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 37.8(4) "h"(10);

(7) Blood: coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph 37.8(4) “h”(10);

(8) Medicare Part B cost sharing: except for coverage provided in subparagraph 37.8(4) “h”(9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the covered individual pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 37.8(4) “h”(10);

(9) Medicare Part B preventive services: coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the covered individual pays the Medicare Part B deductible; and

(10) Cost sharing after out-of-pocket limits reached: coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

i. Plan L is mandated by the MMA and shall include only the following:

(1) The benefits described in subparagraphs 37.8(4) “h”(1), (2), (3) and (9);

(2) The benefits described in subparagraphs 37.8(4) “h”(4), (5), (6), (7) and (8), but substituting 75 percent for 50 percent; and

(3) The benefit described in subparagraph 37.8(4) “h”(10), but substituting \$2,000 for \$4,000.

j. Plan M shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “b,” “c,” and “f,” respectively.

k. Plan N shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “a,” “c,” and “f,” respectively, with copayments in the following amounts:

(1) The lesser of \$20 or the Medicare Part B coinsurance or copayment for each covered provider office visit (including visits to medical specialists); and

(2) The lesser of \$50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the covered individual is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

37.8(5) *New or innovative benefits.* An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.9(514D) Standard Medicare supplement benefit plans for 2020 standardized Medicare supplement benefit plan policies or certificates issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires that the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement

policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of rules 191—37.6(514D), 191—37.7(514D) and 191—37.8(514D).

37.9(1) *Benefit requirements.* The standards and requirements of rule 191—37.8(514D) shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

a. Plan C is redesignated as Plan D and shall provide the benefits contained in paragraph 37.8(4) “*c*” but shall not provide coverage for 100 percent or any portion of the Medicare Part B deductible.

b. Plan F is redesignated as Plan G and shall provide the benefits contained in paragraph 37.8(4) “*e*” but shall not provide coverage for 100 percent or any portion of the Medicare Part B deductible.

c. Plans C, F, and F with high deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

d. Plan F with high deductible is redesignated as Plan G with high deductible and shall provide the benefits contained in paragraph 37.8(4) “*f*,” but shall not provide coverage for 100 percent or any portion of the Medicare Part B deductible; provided further that the Medicare Part B deductible paid by the covered individual shall be considered an out-of-pocket expense in meeting the annual high deductible.

e. The reference to Plan C or F contained in paragraph 37.8(2) “*b*” is deemed a reference to Plan D or G for purposes of this rule.

37.9(2) *Applicability to certain newly eligible individuals.* This rule applies only to individuals who are newly eligible for Medicare on or after January 1, 2020, by reason of:

a. Attaining age 65 on or after January 1, 2020; or

b. Entitlement to benefits under Medicare Part A pursuant to Section 226(b) or 226A of the Social Security Act, or who are deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020.

37.9(3) *Guaranteed issue for eligible persons.* For purposes of rule 191—37.36(514D), in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement Plan C or F (including Plan F with high deductible) shall be deemed to be a reference to Medicare supplement Plan D or G (including Plan G with high deductible), respectively, that meets the requirements of this rule.

37.9(4) *Offer of redesignated plans to individuals other than newly eligible.* On or after January 1, 2020, the standardized benefit plans described in paragraph 37.9(1) “*d*” may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in subrule 37.8(4).

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.10 to 37.19 Reserved.

191—37.20(514D) Medicare Select policies and certificates.

37.20(1) *Applicability of this rule.*

a. Rule 191—37.20(514D) shall apply to Medicare Select policies and certificates, as defined in this rule.

b. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this rule.

37.20(2) *Definitions.* For the purposes of this rule, in addition to the definitions of Iowa Code section 514D.2, and of rules 191—37.3(514D) and 191—37.4(514D), the following definitions shall apply:

“*Complaint*” means any dissatisfaction expressed by a covered individual concerning a Medicare Select issuer or a Medicare Select network provider.

“*Grievance*” means dissatisfaction expressed in writing by a covered individual under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its Medicare Select network providers.

“*Medicare Select issuer*” means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

“*Medicare Select network provider*” means a provider of health care, or a group of providers of health care, which has entered into a written agreement with a Medicare Select issuer to provide benefits insured under a Medicare Select policy or certificate.

“*Medicare Select policy*” means a Medicare supplement individual policy that contains a restricted network provision; “*Medicare Select certificate*” means an individual’s certificate of coverage under a group Medicare supplement policy that contains restricted network provisions; and “*Medicare Select policy or certificate*” means either a Medicare Select policy or a Medicare Select certificate.

“*Restricted network provision*” means any provision in a Medicare Select policy or certificate which conditions the payment of benefits, in whole or in part, on the use of Medicare Select network providers belonging to a network specified by the Medicare Select policy or certificate.

“*Service area*” means the geographic area, approved by the commissioner as part of the Medicare Select issuer’s plan of operation, within which the Medicare Select issuer is authorized to offer a Medicare Select policy or certificate.

37.20(3) *Authorization to offer Medicare Select policies or certificates.* The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this rule and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the commissioner finds, upon review and approval of the plan of operation filed in accordance with subrule 37.20(5), that the issuer has satisfied all of the requirements of this chapter.

37.20(4) *Prohibition against offering Medicare Select policies or certificates without approved plan of operation.* A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner, and the commissioner has authorized the issuer to offer Medicare Select policies or certificates, pursuant to subrule 37.20(3).

37.20(5) *Medicare Select issuer shall file a proposed plan of operation.* An issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner and receive approval of the proposed plan from the commissioner prior to offering Medicare Select policies or certificates. The plan of operation shall contain at a minimum all of the information required by paragraphs 37.20(5)“a” through “g” as follows:

a. Evidence that all services covered under the Medicare Select policies or certificates that are subject to restricted network provisions are available and accessible through Medicare Select network providers, including a demonstration that the issuer has met all of the conditions in subparagraphs 37.20(5)“a”(1) through (5) as follows:

(1) Such services can be provided by Medicare Select network providers with reasonable promptness with respect to geographic location, hours of operation and after-hours care. The hours of operation and availability of after-hours care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(2) The number of Medicare Select network providers in the service area is sufficient, with respect to current and expected covered individuals, either:

1. To adequately deliver all services that are subject to a restricted network provision; or
2. To make appropriate referrals.

(3) There are written agreements with Medicare Select network providers describing specific responsibilities.

(4) Emergency care is available 24 hours per day and seven days per week.

(5) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with Medicare Select network providers prohibiting such Medicare Select network providers from billing or otherwise seeking reimbursement from or recourse against any covered individual under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

b. A statement or map providing a clear description of the service area.

c. A description of the grievance procedure to be utilized, that is compliant with subrule 37.20(11).

- d.* A description of the quality assurance program, including:
 - (1) The formal organizational structure;
 - (2) The written criteria for selection, retention and removal of Medicare Select network providers;and
- (3) The procedures for evaluating quality of care provided by Medicare Select network providers, and the process to initiate corrective action when warranted.
- e.* A list and description, by specialty, of the Medicare Select network providers.
- f.* Copies of the written information proposed to be used by the Medicare Select issuer to comply with subrule 37.20(9).

- g.* Any other information requested by the commissioner.

37.20(6) *Filing of changes and updates to Medicare Select issuer's plan of operations.*

- a.* A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of Medicare Select network providers, with the commissioner prior to implementing such changes. Such changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

- b.* An updated list of Medicare Select network providers shall be filed with the commissioner at least quarterly.

37.20(7) *Use of restricted network provision prohibited under certain circumstances.* A Medicare Select policy or certificate issuer shall not apply a restricted network provision to limit a payment amount for covered services provided by providers that are not restricted network providers if:

- a.* The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

- b.* It is not reasonable to obtain such services through a Medicare Select network provider.

37.20(8) *Full coverage for services required under certain circumstances.* A Medicare Select policy or certificate shall provide payment for full coverage under the Medicare Select policy for covered services that are not available through Medicare Select network providers.

37.20(9) *Content of required disclosure.* A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at a minimum all of the information described in paragraphs 37.20(9)“a” through “g” as follows:

- a.* An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

- (1) Other Medicare supplement policies or certificates offered by the Medicare Select issuer; and
- (2) Other Medicare Select policies or certificates.

- b.* A description (including address, telephone number and hours of operation) of the Medicare Select network providers, including primary care physicians, specialty physicians, hospitals and other providers.

- c.* A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than Medicare Select network providers are utilized. Except to the extent specified in the Medicare Select policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in Medicare Select Plans K and L.

- d.* A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

- e.* A description of limitations on referrals to Medicare Select network providers and to other providers.

- f.* A description of the covered individual's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the Medicare Select issuer.

- g.* A description of the Medicare Select issuer's quality assurance program and grievance procedure.

37.20(10) *Acknowledgment.* Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received

the information provided pursuant to subrule 37.20(9) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

37.20(11) *Complaint and grievance procedures.* A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the covered individuals. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

a. The grievance procedure shall be described in the Medicare Select policy or certificate and in the outline of coverage.

b. At the time the Medicare Select policy or certificate is issued, the Medicare Select issuer shall provide detailed information to the covered individual describing how a grievance may be registered with the Medicare Select issuer.

c. The Medicare Select issuer shall consider grievances in a timely manner and shall transmit them to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

d. If a grievance is found to be valid, corrective action shall be taken promptly.

e. All concerned parties shall be notified by the Medicare Select issuer about the results of a grievance.

f. The Medicare Select issuer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the prior calendar year and a summary of the subject, nature and resolution of such grievances.

37.20(12) *Opportunity to purchase another policy at time of purchase.* At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the Medicare Select issuer.

37.20(13) *Opportunity to purchase another policy after issue.*

a. At the request of a covered individual under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the covered individual the opportunity to purchase a Medicare supplement policy or certificate offered by the Medicare Select issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The Medicare Select issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

b. For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Medicare Part B excess charges.

37.20(14) *Continuation of coverage.* Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary determines that Medicare Select policies and certificates issued pursuant to this rule should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or the substantial amendment of the Medicare Select program.

a. Each Medicare Select issuer shall make available to each insured individual under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the Medicare Select issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The Medicare Select issuer shall make such policies and certificates available without requiring evidence of insurability.

b. For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Medicare Part B excess charges.

37.20(15) Compliance with data requests. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the U.S. Department of Health and Human Services, for the purpose of evaluating the Medicare Select program.
[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.21(514D) Open enrollment.

37.21(1) Denial of policy for health reason prohibited. No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, or discriminate in the pricing of such a Medicare supplement policy or certificate, because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a Medicare supplement policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subrule without regard to age.

37.21(2) When preexisting condition exclusion cannot be applied.

a. Definition of “continuous period of creditable coverage.” For purposes of this subrule, “continuous period of creditable coverage” means the period during which a covered individual was covered by creditable coverage, if during the period of the coverage the covered individual had no breaks in coverage greater than 63 days.

b. No preexisting condition exclusion. If an applicant under subrule 37.21(1) submits an application during the time period referenced in subrule 37.21(1) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

c. Reduced time of preexisting condition exclusion. If the applicant qualifies under subrule 37.21(1) and submits an application during the time period referenced in subrule 37.21(1) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the Medicare Select issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subrule.

37.21(3) When benefits can be excluded because of preexisting condition. Subrule 37.21(1) shall not be construed, except as provided in rule 191—37.33(514D) or 191—37.36(514D), as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the covered individual received treatment or was otherwise diagnosed during the six months before the coverage became effective.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.22(514D) Standards for claims payment.

37.22(1) Compliance with OBRA. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

a. Accepting a notice from an issuer on dually assigned claims submitted by participating providers and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

b. Notifying the participating provider or supplier and the beneficiary of the payment determination;

c. Paying the participating provider or supplier directly;

d. Furnishing, at the time of enrollment, each covered individual with a card listing the policy name, number and a central mailing address to which notices from an issuer may be sent;

e. Paying user fees for claim notices that are transmitted electronically or otherwise; and

f. Providing to the Secretary, at least annually, the issuer’s central mailing address to which all claims may be sent by other issuers.

37.22(2) Certification of compliance with OBRA. Compliance with the requirements set forth in 37.22(1) shall be certified on the Medicare supplement insurance experience reporting form. [ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.23(514D) Loss ratio standards and refund or credit of premium.

37.23(1) Definitions. For the purposes of this rule:

“*Health care expenses*” means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of issuers.

“*Type*” means one of the following: an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

37.23(2) Loss ratio standards.

a. Calculations.

(1) A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the Medicare supplement policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to covered individuals one of the following amounts in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

1. At least 75 percent of the aggregate amount of premiums earned in the case of group Medicare supplement policies, or

2. At least 65 percent of the aggregate amount of premiums earned in the case of individual Medicare supplement policies.

(2) The percentages in subparagraph 37.23(2)“*a*”(1) are to be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

(3) For purposes of subparagraph 37.23(2)“*a*”(2), “incurred health care expenses where coverage is provided by a health maintenance organization” shall not include:

1. Home office and overhead costs;
2. Advertising costs;
3. Commissions and other acquisition costs;
4. Taxes;
5. Capital costs;
6. Administrative costs; and
7. Claims processing costs.

b. Filing demonstration of compliance. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this rule when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

c. Certain direct sales. For purposes of applying paragraph 37.23(2)“*a*” only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

d. Prestandardized plans. For all policies issued prior to January 1, 1992, expected claims in relation to premiums shall meet:

(1) The originally filed anticipated loss ratio when combined with the actual experience from inception;

(2) The appropriate loss ratio requirement from paragraphs “1” and “2” of subparagraph 37.23(1)“*a*”(1) when combined with actual experience beginning with January 1, 1996, to date; and

(3) The appropriate loss ratio requirement from paragraphs “1” and “2” of subparagraph 37.23(1)“*a*”(1) over the entire future period for which rates are computed to provide coverage.

37.23(3) Refund or credit calculation.

a. An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the reporting form contained in Appendix A for each type in a standardized Medicare supplement benefit plan (SMSBP).

b. If, on the basis of the experience as reported, the benchmark ratio since inception (Appendix A, ratio 1) exceeds the adjusted experience ratio since inception (Appendix A, ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in an SMSBP. For purposes of the refund or credit calculation, experience on SMSBP policies issued within the reporting year shall be excluded.

c. For purposes of this rule, for SMSBP policies or certificates issued prior to January 1, 1992, the issuer shall make the refund or credit calculation separately for all individual SMSBP policies (including all group SMSBP policies subject to an individual loss ratio standard when issued) combined and all other group SMSBP policies combined for experience after January 1, 1996. The first report shall be due May 31, 1998.

d. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

37.23(4) Annual filing of premium rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of January 1, 1992, in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by SMSBP policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

a. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed.

(1) Such demonstration shall exclude active life reserves.

(2) An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for SMSBP policies or certificates in force less than three years.

b. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state, the following:

(1) Such supporting documents as necessary to justify that the adjustments are appropriate.

1. Appropriate premium adjustments shall be those which:

- Are necessary to produce loss ratios as anticipated for the current premium for the applicable SMSBP policies or certificates;

- Are necessary to produce an expected loss ratio under such SMSBP policies or certificates as will conform with minimum loss ratio standards for SMSBP policies or certificates; and

- Are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such SMSBP policies or certificates.

2. No premium adjustment which would modify the loss ratio experience under the SMSBP policy other than the adjustments described herein shall be made with respect to an SMSBP policy at any time other than upon its renewal date or anniversary date.

3. If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this rule.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the SMSBP policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the SMSBP policy or certificate.

37.23(5) Public hearings. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for an SMSBP policy form or certificate form issued before or after the effective date of January 1, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is to be made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner. [ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.24(514D) Filing and approval of policies and certificates and premium rates.

37.24(1) Definition. For the purposes of this rule:

“Type” means one of the following: an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

37.24(2) Form filing and approval required. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the SMSBP policy form or certificate form has been filed pursuant to rule 191—20.1(505,509,514A,515,515A,515F) and approved by the commissioner.

37.24(3) MMA requirements to be filed with state of issue. An issuer shall file any riders or amendments to SMSBP policy or certificate forms to delete outpatient prescription drug benefits as required by the MMA only with the commissioner in the state in which the policy or certificate was issued.

37.24(4) Rate filing and approval required. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

37.24(5) One form per type.

a. Except as provided in paragraph 37.24(5)“*b*,” an issuer shall not file for approval more than one form of a policy or certificate of each type for each SMSBP.

b. An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same SMSBP, one for each of the following cases:

- (1) The inclusion of new or innovative benefits;
- (2) The addition of either direct response or producer marketing methods;
- (3) The addition of either guaranteed issue or underwritten coverage;
- (4) The offering of coverage to individuals eligible for Medicare by reason of disability.

37.24(6) Forms to be kept available once approved.

a. Except as provided in subparagraph 37.24(6)“*a*”(1), an issuer shall continue to make available for purchase any SMSBP policy form or certificate form issued after January 1, 1992, that has been approved by the commissioner. An SMSBP policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(1) An issuer may discontinue the availability of an SMSBP policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the SMSBP policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the SMSBP policy form or certificate form in this state.

(2) An issuer that discontinues the availability of an SMSBP policy form or certificate form pursuant to subparagraph 37.24(6)“*a*”(1) shall not file for approval of a new SMSBP policy form or certificate form of the same type for the same SMSBP as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

b. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subrule.

c. A change in the rating structure or methodology shall be considered a discontinuance under paragraph 37.24(6)“*a*” unless the issuer complies with the following requirements:

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(2) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

37.24(7) Experience under forms of same type to be combined for calculations.

a. Except as provided in paragraph 37.24(7)“b,” the experience under all SMSBP policy forms or certificate forms of the same type in an SMSBP shall be combined for purposes of the refund or credit calculation prescribed in rule 191—37.23(514D).

b. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other policy or certificate forms for purposes of the refund or credit calculation.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.25(514D) Permitted compensation arrangements.

37.25(1) Definition of “compensation.” For purposes of this rule:

“Compensation” includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the Medicare supplement or Medicare Select policy or certificate including, but not limited to, bonuses, gifts, prizes, awards and finder’s fees.

37.25(2) Compensation to producer for sales. An issuer or other entity may provide a commission or other compensation to a producer or other representative for the sale of a Medicare supplement policy or certificate only if the first-year commission or other first-year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the Medicare supplement policy or certificate in the second year or period.

37.25(3) Compensation to producer for renewals. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

37.25(4) Compensation for renewals involving replacement. No issuer or other entity shall provide compensation to its producers and no producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal Medicare supplement policies or certificates if an existing Medicare supplement policy or certificate is replaced.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.26(514D) Required notice regarding policies or certificates which are not Medicare supplement policies or certificates.

37.26(1) Issuer required to disclose that a policy is not a Medicare supplement policy. An issuer of any accident and sickness insurance policy or certificate issued for delivery in this state to a person eligible for Medicare shall notify the insured under the policy that the policy is not a Medicare supplement policy or certificate, if the policy or certificate is not a Medicare supplement policy or certificate.

a. The notice shall either be printed or attached to the first page of the outline of coverage delivered to the insured under the accident and sickness policy or, if no outline of coverage is delivered, to the first page of the policy or certificate delivered to the insured.

b. The notice shall be in no less than 12-point type and shall contain the following language:

“THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services] available from the company.”

c. The notice requirement of this subrule 37.26(1) shall not apply to an accident and sickness insurance policy or certificate that is a Medicare supplement policy or certificate, a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.), a disability income policy, or any other policy excepted by rule 191—37.2(514D).

37.26(2) Issuer required to disclose extent of duplication of Medicare. When providing an application to persons eligible for Medicare for the health insurance policies or certificates described in subrule 37.26(1), except for policies or certificates excluded by paragraph 37.26(1)“c,” issuers shall disclose the extent to which a policy duplicates Medicare. The disclosure shall use the applicable statement in Appendix B and shall be provided as a part of, or together with, the application for the policy or certificate.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.27(514D) Requirements for application forms and replacement coverage.

37.27(1) Application to include Appendix C. Application forms for Medicare supplement policies or certificates shall include in the outline of coverage the “statements and questions for application forms related to duplicate or replacement coverage” set forth in Appendix C, in the order prescribed in Appendix C, designed to elicit the following information, as of the date of the application: whether the applicant currently has a Medicare supplement policy or certificate, a Medicare Advantage policy or certificate, or other Medicaid coverage; whether the applicant has another health insurance policy or certificate in force; or whether the applicant intends a Medicare supplement policy or certificate to replace any other accident and sickness policy or certificate presently in force. An additional page or form containing such questions and statements and the applicant’s responses may be used, but it must be signed by the applicant and producer, attached to the application, and kept together with the issuer’s records.

37.27(2) List of policies sold to applicant. Producers shall list on the form or on an attachment to the form of Appendix C any other health insurance policies they have sold to the applicant, including the following:

- a. Policies sold which are still in force.
- b. Policies sold in the prior five years which are no longer in force.

37.27(3) Direct response sales. In the case of a direct response issuer, a copy of the application or additional page or form, signed by the applicant and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy and shall include the notice regarding replacement of Medicare supplement coverage required of direct response issuers by subrule 37.27(4).

37.27(4) Required notice regarding replacement. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its producer, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. The notice shall be provided in the format described in subrule 37.27(5). One copy of such notice signed by the applicant and the producer, except where the coverage is sold without a producer, shall be provided to the applicant, and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

37.27(5) Required format of notice regarding replacement. The notice required by subrule 37.27(4) for an issuer shall be provided in substantially the form and language of the Notice to Applicant regarding Replacement of Medicare Supplement Insurance or Medicare Advantage, as set forth in Appendix D, in no less than 12-point type. Statements 1 and 2 of the replacement notice of Appendix D (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.28(514D) Required disclosure provisions.

37.28(1) General rules.

a. A Medicare supplement policy or certificate shall include renewal or continuation provisions. The language or specifications of such provisions shall be consistent with the type of Medicare supplement policy issued. Such provisions shall be appropriately captioned and shall appear on the first page of the Medicare supplement policy or certificate, and shall include any reservations by the issuer of the right to change premiums and any automatic renewal premium increases based on the covered individual’s age.

b. Except for a rider or an endorsement by which the issuer effectuates a request made in writing by the covered individual, exercises a specifically reserved right under a Medicare supplement policy or certificate, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, any rider or endorsement added to a Medicare supplement policy or certificate after the date the policy or certificate is issued, or at reinstatement or renewal, which reduces or eliminates benefits or coverage in the policy or certificate shall require a signed acceptance by the covered individual. After the date of issue of a Medicare supplement policy or certificate, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the covered individual, unless the benefits are required by the minimum standards for Medicare supplement policies or certificates, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with a rider or endorsement, such premium charge shall be set forth in the Medicare supplement policy or certificate.

c. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import.

d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the Medicare supplement policy or certificate and be labeled as “Preexisting Condition Limitations.”

e. A Medicare supplement policy or certificate shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto, stating in substance that the covered individual shall have the right to return the Medicare supplement policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the Medicare supplement policy or certificate, the covered individual is not satisfied for any reason.

f. An issuer of an accident or sickness policy or certificate which provides hospital or medical expense coverage on an expense-incurred or indemnity basis to an individual eligible for Medicare shall provide to any applicant for such policy or certificate the most recent version of *Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services (“guide”), developed jointly by the National Association of Insurance Commissioners and CMS, using the same language, format, type size (no less than 12 point), type-proportional spacing, bold characters and line spacing. Delivery of the guide shall be made whether or not such policy or certificate was advertised, solicited or issued as a Medicare supplement policy or certificate as defined in this chapter. Except in the case of a direct response issuer, delivery of the guide shall be made to the applicant at the time of application and acknowledgment of receipt of the guide shall be obtained by the issuer. A direct response issuer shall deliver the guide to the applicant upon request but not later than at the time the Medicare supplement policy is delivered.

37.28(2) Notice requirements.

a. As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its covered individuals of modifications it has made to Medicare supplement policies or certificates in a format acceptable to the commissioner. The notice shall:

- (1) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and
- (2) Inform each covered individual as to when any premium adjustment is to be made due to changes in Medicare.

b. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

c. Such notices shall not contain or be accompanied by any solicitation.

37.28(3) MMA notice requirements. Issuers shall comply with any notice requirements of the MMA.

37.28(4) Outline of coverage requirements for Medicare supplement policies.

a. An issuer shall provide an outline of coverage to any applicant for a Medicare supplement policy or certificate at the time application is presented to the prospective applicant and, except for a direct response policy, shall obtain an acknowledgment of receipt of such outline of coverage from the applicant.

b. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, the issuer shall provide a substitute outline of coverage properly describing the Medicare supplement policy or certificate to accompany such Medicare supplement policy or certificate when it is delivered to the covered individual, and the substitute outline of coverage shall contain the following statement, in no less than 12-point type, immediately above the issuer's company name:

“NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.”

c. The outline of coverage provided to an applicant pursuant to this rule shall consist of the following four parts: a cover page; premium information; disclosure pages; and charts displaying the features of each Medicare supplement benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in this rule and in Appendix E in no less than 12-point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered by the issuer shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

d. The items in Appendix E shall be included in the outline of coverage in the order prescribed in Appendix E.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.29 Reserved.

191—37.30(514D) Standards for marketing.

37.30(1) Requirements for marketing. An issuer, directly or through its producers, shall:

a. Establish marketing procedures to ensure that any comparison of policies or certificates by its producers will be fair and accurate.

b. Establish marketing procedures to ensure excessive insurance is not sold or issued.

c. Display prominently by type, stamp or other appropriate means, on the first page of the policy or certificate, the following:

“Notice to buyer: This policy may not cover all of your medical expenses.”

d. Inquire and otherwise make every reasonable effort to identify whether a prospective covered individual for Medicare supplement policy or certificate already has accident and sickness insurance and the types and amounts of any such insurance.

e. Establish auditable procedures for certifying compliance with this subrule.

f. At solicitation, provide written notice to the prospective covered individual of the name, address, and telephone number of the senior health insurance information program, part of the insurance division. The written notice shall be in a form prescribed by the commissioner.

37.30(2) Prohibitions in marketing. In addition to the practices prohibited in Iowa Code chapter 507B, 191—Chapter 15 and other rules promulgated under Iowa Code chapter 507B, and rule 191—37.50(514D), the following acts and practices are prohibited:

a. *Twisting.* Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or certificates, or of any issuers, for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or certificate or to take out a policy or certificate of insurance with another issuer.

b. *High-pressure tactics.* Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

c. *Cold-lead advertising.* Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

37.30(3) Prohibited terms in noncompliant policies or certificates. The terms “Medicare supplement,” “Medigap,” “Medicare wrap-around” and words of similar import shall not be used unless the policy or certificate is issued in compliance with this chapter.
[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.31(514D) Appropriateness of recommended purchase and excessive insurance.

37.31(1) Appropriateness. In recommending the purchase or replacement of any Medicare supplement policy or certificate, a producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

37.31(2) No duplication. Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

37.31(3) No Medicare supplement for enrollee in Part C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual’s Medicare Part C coverage.
[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.32(514D) Reporting of multiple policies.

37.32(1) Report of in-force Medicare supplement covered individuals. On or before March 1 of each year, an issuer shall report, using the format of Appendix F, the following information for every covered individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

- a. Policy and certificate number; and
- b. Date of issuance.

37.32(2) Grouping of items. The items set forth in subrule 37.21(1) must be grouped by covered individual.
[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.33(514D) Prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates.

37.33(1) Time credited from prior policy or certificate. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new replacing Medicare supplement policy or certificate to the extent such time was spent under the replaced policy.

37.33(2) Similar benefits credited from prior policy or certificate. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing Medicare supplement policy or certificate shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the replaced policy or certificate.
[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.34(514D) Prohibitions against use of genetic information and against requests for genetic testing. This rule applies to all Medicare supplement policies or certificates with policy years beginning on or after May 21, 2009.

37.34(1) Definitions. For the purposes of this rule, the following definitions shall apply:

“*Family member*” means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

“*Genetic information*” means, with respect to any individual, information about such individual’s genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. “Genetic information” includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant

woman includes genetic information of any fetus carried by such pregnant woman or, with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term “genetic information” does not include information about the sex or age of any individual.

“*Genetic services*” means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

“*Genetic test*” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. The term “genetic test” does not mean:

1. An analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or
2. An analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

“*Issuer of a Medicare supplement policy or certificate*” means the same as “issuer” as defined in rule 191—37.3(514D) and includes a third-party administrator, or other person acting for or on behalf of such issuer.

“*Underwriting purposes*” means:

1. Rules for or determination of eligibility (including enrollment and continued eligibility) for benefits under the Medicare supplement policy or certificate;
2. The computation of premium or contribution amounts under the Medicare supplement policy or certificate;
3. The application of any preexisting condition exclusion under the Medicare supplement policy or certificate; and
4. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

37.34(2) *Use of genetic information by issuer prohibited.* An issuer of a Medicare supplement policy or certificate:

- a. Shall not deny or condition the issuance or effectiveness of the Medicare supplement policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) of an individual on the basis of the genetic information with respect to such individual; and
- b. Shall not discriminate in the pricing of the Medicare supplement policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

37.34(3) *What prohibition does not include.* Nothing in subrule 37.34(2) shall be construed to limit the ability of an issuer of a Medicare supplement policy or certificate, to the extent otherwise permitted by law, from:

- a. Denying or conditioning the issuance or effectiveness of the Medicare supplement policy or certificate or increasing the premium for a group plan based on the manifestation of a disease or disorder of a covered individual or applicant; or
- b. Increasing the premium for any Medicare supplement policy or certificate issued to an individual based on the manifestation of a disease or disorder of another individual who is covered under the Medicare supplement policy. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the insured group.

37.34(4) *Issuer prohibited from requiring genetic testing.* An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

37.34(5) *Obtaining and using test results to determine payment.* Subrule 37.34(4) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under Medicare Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time)

and consistent with subrule 37.34(2). However, for purposes of carrying out this subrule, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

37.34(6) *Conditions when issuer may request a genetic test.* Notwithstanding subrule 37.34(4), an issuer of a Medicare supplement policy or certificate may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

a. The request is made pursuant to research that complies with Part 46 of Title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

b. The issuer of a Medicare supplement policy or certificate clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(1) Compliance with the request is voluntary; and

(2) Noncompliance will have no effect on enrollment status or premium or contribution amounts.

c. No genetic information collected or acquired under this subrule shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a Medicare supplement policy or certificate.

d. The issuer of a Medicare supplement policy or certificate notifies the Secretary in writing that the issuer of a Medicare supplement policy or certificate is conducting activities pursuant to the exception provided for under this subrule, including a description of the activities conducted.

e. The issuer of a Medicare supplement policy or certificate complies with such other conditions as the Secretary may by regulation require for activities conducted under this subrule.

37.34(7) *Issuer prohibited from actively obtaining genetic information for underwriting.* An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

37.34(8) *Issuer prohibited from actively obtaining genetic information for enrollment.* An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

37.34(9) *Obtaining information incidentally not a violation.* If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subrule 37.34(8) if such request, requirement, or purchase is not in violation of subrule 37.34(7).

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.35(514D) Prohibition against using materials prepared by SHIIP. The Senior Health Insurance Information Program (SHIIP) may prepare a consumer Medicare supplement insurance premium guide and benefits comparison guide. This guide and the SHIIP name or logo shall not be used in the solicitation or sale of health insurance products. Violation of this rule shall be deemed an unfair trade practice under Iowa Code chapter 507B.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.36(514D) Guaranteed issue for eligible persons.

37.36(1) *Definition of "Medicare Advantage organization."* For purposes of this rule:

"Medicare Advantage organization" means a private company that has a contract with Medicare to provide Medicare Advantage plans and benefits to individuals.

37.36(2) *Guaranteed issue.*

a. Eligible persons for guaranteed issue of a Medicare supplement policy or certificate are those individuals described in subrule 37.36(3) who seek to enroll under the Medicare supplement policy during the period specified in subrule 37.36(4) and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy or certificate.

b. With respect to eligible individuals for guaranteed issue of a Medicare supplement policy or certificate, an issuer: shall not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate described in subrule 37.36(6) that is offered by the issuer and is available for issuance to new enrollees; shall not discriminate in the pricing of such Medicare supplement policy or certificate because of health status, claims experience, receipt of health care, or medical condition; and shall not impose an exclusion of benefits based on a preexisting condition under such Medicare supplement policy or certificate.

37.36(3) Eligible persons. An eligible person is an individual described in any of the following paragraphs 37.36(3) “a” through “g”:

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement benefits under Medicare, and the plan terminates or the plan ceases to provide some or all such supplemental health benefits to the individual (for purposes of this paragraph, “employee welfare benefit plan” means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 Employee Retirement Income Security Act).

b. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a PACE provider and circumstances exist similar to one of the circumstances described in subparagraphs 37.36(3) “b”(1) through (5) that would permit discontinuance of the individual’s enrollment with such a provider if such individual were enrolled in a Medicare Advantage plan:

(1) The certification of the Medicare Advantage organization or Medicare Advantage plan has been terminated.

(2) The Medicare Advantage organization has terminated or otherwise discontinued providing the Medicare Advantage plan in the area in which the individual resides.

(3) The individual is no longer eligible to elect the Medicare Advantage plan because of a change in the individual’s place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual’s enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the Medicare Advantage plan is terminated for all individuals within a residence area.

(4) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

1. The Medicare Advantage organization offering the Medicare Advantage plan substantially violated a material provision of the Medicare Advantage organization’s contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the Medicare Advantage plan or the failure to provide such covered care in accordance with applicable quality standards; or

2. The Medicare Advantage organization, or agent, producer or other entity acting on the Medicare Advantage organization’s behalf, materially misrepresented the Medicare Advantage plan’s provisions in marketing the Medicare Advantage plan to the individual.

(5) The individual meets such other exceptional conditions as the Secretary may provide.

c. The individual is one for whom both subparagraphs 37.36(3) “c”(1) and (2) are true:

(1) The individual is enrolled with one of the following organizations:

1. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

2. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

3. An organization operating under an agreement under Section 1833(a)(1)(A) of the Social Security Act (Health Care Prepayment Plan (HCPP)); or

4. An organization under a Medicare Select policy.

(2) The enrollment ceases under the same circumstances that would permit discontinuance of an individual’s election of coverage under paragraph 37.36(3) “b.”

d. The individual is enrolled under a Medicare supplement policy or certificate, and the enrollment ceases because:

(1) Of the insolvency or rehabilitation of the issuer (pursuant to Iowa Code chapter 507C) or the bankruptcy of the Medicare Advantage organization; or of other involuntary termination of coverage or enrollment under the policy (for purposes of this subparagraph, “bankruptcy” means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy, and has ceased doing business in the state); or

(2) The issuer of the policy substantially violated a material provision of the policy; or

(3) The issuer, or an agent, producer or other entity acting on the issuer’s behalf, materially misrepresented the policy’s provisions in marketing the policy to the individual.

e. The individual was enrolled under a Medicare supplement policy or certificate and terminated enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider, or a Medicare Select policy; and the subsequent enrollment under this paragraph 37.36(3) “*e*” was terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act).

f. The individual, upon first becoming enrolled for benefits under Medicare Part B at age 65 or older, enrolls in a Medicare Advantage plan under Medicare Part C, or with a PACE provider, and disenrolls from the plan or program by no later than 12 months after the effective date of enrollment.

g. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Medicare Part D, was enrolled under a Medicare supplement policy or certificate that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy or certificate and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph 37.36(6) “*e*.”

37.36(4) *Guaranteed issue time periods.*

a. In the case of an individual described in paragraph 37.36(3) “*a*,” the guaranteed issue period:

(1) Begins on the later of:

1. The date the individual receives a notice of termination or cessation of some or all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or

2. The date that the applicable coverage terminates or ceases; and

(2) Ends 63 days thereafter.

b. In the case of an individual described in paragraph 37.36(3) “*b*,” “*c*,” “*e*” or “*f*” whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

c. In the case of an individual described in subparagraph 37.36(3) “*d*”(1), the guaranteed issue period:

(1) Begins on the earlier of:

1. The date that the individual receives a notice of termination, a notice that the issuer is insolvent or in rehabilitation (pursuant to Iowa Code chapter 507C), or other such similar notice, if any; and

2. The date that the applicable coverage is terminated; and

(2) Ends on the date that is 63 days after the date the coverage is terminated.

d. In the case of an individual described in paragraph 37.36(3) “*b*,” subparagraph 37.36(3) “*d*”(2) or (3), or paragraph 37.36(3) “*e*” or “*f*” who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

e. In the case of an individual described in paragraph 37.36(3) “*g*,” the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement or certificate issuer during the 60-day period immediately preceding

the initial Medicare Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

f. In the case of an individual described in subrule 37.36(3) but not described in the preceding paragraphs 37.36(4) "a" to "e," the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

37.36(5) *Extended Medigap access for interrupted trial periods.*

a. In the case of an individual described in subrule 37.36(3) (or deemed to be so described pursuant to this paragraph 37.36(5) "a") whose enrollment with an organization or provider described in paragraph 37.36(3) "e" is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment as described in paragraph 37.36(3) "e."

b. In the case of an individual described in paragraph 37.36(3) "f" (or deemed to be so described pursuant to this paragraph 37.36(5) "b") whose enrollment with a plan or in a program described in paragraph 37.36(3) "f" is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment as described in paragraph 37.36(3) "f."

c. For purposes of paragraphs 37.36(3) "e" and "f," no enrollment of an individual with an organization or provider described in paragraph 37.36(3) "e," or with a plan or in a program described in paragraph 37.36(3) "f," may be deemed to be an initial enrollment under this paragraph 37.36(5) "c" after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

37.36(6) *Products to which eligible persons are entitled.*

a. If an individual meets the requirements of paragraph 37.36(3) "a," "b," "c," or "d," the individual may be issued a Medicare supplement policy or certificate which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

b. The Medicare supplement policy or certificate to which eligible persons are entitled under paragraph 37.36(3) "e," subject to paragraph 37.36(6) "c," is the same Medicare supplement policy or certificate in which the individual was most recently previously enrolled if available from the same issuer, or, if not so available, a policy described in paragraph 37.36(6) "a."

c. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy or certificate with an outpatient prescription drug benefit, a Medicare supplement policy or certificate described in this subrule is:

(1) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(2) At the election of the individual, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer.

d. The Medicare supplement policy or certificate to which eligible persons are entitled under paragraph 37.36(3) "f" shall include any Medicare supplement policy or certificate offered by any issuer.

e. The Medicare supplement policy or certificate to which eligible persons are entitled under paragraph 37.36(3) "g" is a Medicare supplement policy or certificate that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy or certificate with outpatient prescription drug coverage.

37.36(7) *Notification of provisions.*

a. At the time of an event described in subrule 37.36(3) because of which an individual loses coverage or benefits due to the termination or change of a contract or agreement, policy, or plan, the organization that terminates or changes the contract or agreement, the issuer terminating or changing the policy, or the administrator of the plan being terminated or changed, respectively, shall notify the individual of the individual's rights under this rule and of the obligations of issuers of Medicare supplement policies or certificates under subrule 37.36(2). Such notice shall be communicated contemporaneously with the notification of termination.

b. At the time of an event described in subrule 37.36(3) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this rule and of the obligations of issuers of Medicare supplement policies or certificates under subrule 37.36(3). Such notice shall be communicated within ten working days of the issuer receiving notification of the disenrollment.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.37 to 37.49 Reserved.

191—37.50(507B,514D) Medicare supplement advertising.

37.50(1) Purpose. The purpose of this rule is to provide prospective purchasers with clear and unambiguous statements in the advertisement of Medicare supplement insurance and to ensure the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as Medicare supplement insurance. This purpose is intended to be accomplished by the establishment of guidelines and permissible and impermissible standards of conduct in the advertising of Medicare supplement insurance in a manner which prevents unfair, deceptive and misleading advertising and which is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by producers and companies.

37.50(2) Applicability.

a. This rule shall apply to any "advertisement" of Medicare supplement insurance, as that term is defined in subrule 37.50(3), unless otherwise specified in this rule, that the issuer or producer knows or reasonably should know is intended for presentation, distribution or dissemination in this state when the presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an issuer or producer.

b. The requirements of Iowa Code chapter 507B and 191—Chapter 15 also shall apply to issuers and producers to which this rule 191—37.50(507B,514D) applies, unless specifically exempted therein.

37.50(3) Definitions. In addition to the definitions in Iowa Code sections 507B.2 and 514D.2 and rules 191—15.2(507B) and 191—37.3(514D), the following definitions shall apply to this rule 191—37.50(507B,514D). When a term defined in this rule is also defined in Iowa Code section 507B.2 or 514D.2 or rule 191—15.2(507B) or 191—37.3(514D), the definition of the term in this rule shall take precedence.

"Advertisement"

1. Includes the definition of "advertisement" in rule 191—15.2(507B).
2. Includes advertising material included with a Medicare supplement policy or certificate when the Medicare supplement policy or certificate is delivered and the advertising material is used in the solicitation of Medicare supplement policy renewals and reinstatements.
3. Does not include:
 - The items excluded in paragraph "2" of the definition of "advertisement" in rule 191—15.2(507B).
 - Material to be used solely for the training and education of an issuer's employees, producers, agents or brokers.
 - Material used in-house by issuers.
 - Communications within an issuer's own organization not intended for dissemination to the public.
 - Individual communications of a personal nature with current covered individuals other than material urging the covered individuals to increase or expand coverage.
 - Correspondence between a prospective group or blanket policyholder and an issuer in the course of negotiating a group or blanket Medicare supplement policy.
 - Court-approved material ordered by a court to be disseminated to covered individuals or group policyholders of Medicare supplement policies.

- A general announcement from a group or blanket Medicare supplement policyholder to eligible individuals on an employment or membership list that a Medicare supplement policy has been written or arranged; provided the announcement clearly indicates that it is preliminary to the issuance of a booklet.

“*Certificate*” means any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this state.

“*Exception*” means any provision in a Medicare supplement policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the Medicare supplement policy or certificate.

“*Institutional advertisement*” means an advertisement having as its sole purpose the promotion of the reader’s, viewer’s or listener’s interest in the concept of Medicare supplement insurance, or the promotion of the issuer as a seller of Medicare supplement insurance.

“*Invitation to contract*” means an advertisement that is neither an institutional advertisement nor an invitation to inquire (defined in paragraph 37.50(8) “d”).

“*Issuer*” shall include any entity which is defined as an “issuer” in rule 191—37.3(514D) and is engaged in the advertisement of itself, or of Medicare supplement insurance.

“*Lead-generating device*” means any communication directed to the public that, regardless of form, content or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of Medicare supplement insurance.

“*Limitation*” means any provision other than an exception or a reduction that restricts coverage under a Medicare supplement policy.

“*Medicare supplement insurance*” means a group or individual policy of accident and sickness insurance or a contract of hospital and medical service associations or health maintenance organizations that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare by reason of age.

“*Person*” means a natural person, association, organization, partnership, trust, group, discretionary group, corporation or any other entity.

“*Reduction*” means any provision that reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than would be otherwise payable had the reduction not been used.

37.50(4) Form and content of advertisements.

a. An issuer shall clearly identify its Medicare supplement insurance as an insurance policy or certificate. A Medicare supplement policy or certificate trade name must be followed by the words “Insurance Policy” or similar words clearly identifying the fact that an insurance policy or certificate or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

b. Medicare supplement insurance advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the issuer.

37.50(5) Testimonials or endorsements by third parties. In addition to complying with 191—subrule 15.3(7), when a testimonial refers to benefits received under a Medicare supplement policy or certificate, the issuer shall retain for examination by the commissioner the specific claim data, including claim number, date of loss, and other pertinent information, for a period of four years or until the filing of the next regular report of examination of the issuer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the issuer or that are not applicable to the Medicare supplement policy or certificate or benefit being advertised is not permissible.

37.50(6) Use of statistics; jurisdictional licensing; status of insurer. Medicare supplement insurance advertisements shall be in compliance with 191—subrule 15.3(5) and with the following:

a. A Medicare supplement insurance advertisement shall specifically identify the Medicare supplement policy or certificate to which statistics relate and, where statistics are given which are

applicable to a different policy or certificate, the advertisement shall state clearly that the data do not relate to the Medicare supplement policy or certificate being advertised.

b. A Medicare supplement insurance advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the issuer is licensed shall not imply licensing beyond those limits.

c. A Medicare supplement insurance advertisement shall not create the impression directly or indirectly that the issuer, the issuer's financial condition or status, the issuer's payment of its claims, or the merits, desirability or advisability of the issuer's policy forms or kinds of plans of insurance are approved, endorsed or accredited by any division or agency of this state or of the United States government.

d. A Medicare supplement insurance advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of this state or of the United States government. "Approval" of either policy forms or advertising shall not be used by an issuer to imply or state that a governmental agency has endorsed or recommended the issuer, its policies, its advertising or its financial condition.

37.50(7) Identity of issuer. Advertisements shall be in compliance with 191—subrule 15.3(9) and with the following:

a. Advertisements, stationery or envelopes that employ words, letters, initials, symbols or other devices are not permitted if they are so similar to those used by governmental agencies or other issuers that they may lead the public to believe:

(1) The advertised Medicare supplement insurance coverages are somehow provided by or are endorsed by the governmental agencies or the other issuers;

(2) The Medicare supplement insurance advertiser is the same as, is connected with or is endorsed by the governmental agencies or the other issuers.

b. No Medicare supplement insurance advertisement shall use the name of a state or political subdivision thereof in a policy name or description.

c. No Medicare supplement insurance advertisement in the form of envelopes or stationery of any kind may use any name, service mark, slogan, symbol or any device in such a manner that implies that the issuer or the policy advertised, or that any producer who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration.

d. No Medicare supplement insurance advertisement may incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating the plan or policy from Medicare. Such an advertisement, however, shall not use the phrase "_____ Medicare Department of the _____ Insurance Company," or language of similar import.

e. No Medicare supplement insurance advertisement shall be used that fails to include a disclaimer to the effect of "Not connected with or endorsed by the U.S. government or the federal Medicare program."

f. No Medicare supplement insurance advertisement may imply that the reader may lose a right, privilege or benefit under federal, state or local law if the reader fails to respond to the advertisement.

g. No issuer may use, in the trade name of its Medicare supplement insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.

h. All Medicare supplement insurance advertisements used by producers or solicitors of an issuer shall have prior written approval of the issuer before the advertisements may be used.

i. A producer who makes contact with a consumer as a result of acquiring that consumer's name from a lead-generating device shall disclose that fact in the initial contact with the consumer.

37.50(8) Introductory, initial or special offers.

a. Enrollment periods.

(1) An advertisement of an individual Medicare supplement insurance policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such representation is true. A

Medicare supplement insurance advertisement shall not contain phrases describing an enrollment period as “special,” “limited,” or similar words or phrases when the issuer uses such enrollment periods as the usual method of advertising Medicare supplement insurance.

(2) An enrollment period during which a particular Medicare supplement insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The Medicare supplement insurance advertisement shall indicate the date by which the applicant must mail the application, which shall be not fewer than 10 days and not more than 40 days from the date that the enrollment period is advertised for the first time. This rule applies to all advertising media, e.g., mail, newspapers, electronic mail, websites, radio, television, magazines and periodicals, used by any one issuer. This rule is not applicable to solicitations of employees or members of a particular group or association that otherwise would be eligible for group, blanket or franchise insurance. The phrase “any one issuer” in this subparagraph includes all the affiliated companies of a group of insurance companies under common management or control. The phrase “a particular Medicare supplement insurance product” in this subparagraph means an insurance policy that provides benefits substantially different from those contained in any other policy. Different terms of renewability, an increase or decrease in the dollar amounts of benefits, or an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product’s being offered as a different product eligible for concurrent or overlapping enrollment periods.

(3) This rule prohibits any statement or implication to the effect that only a specific number of Medicare supplement policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular Medicare supplement policy advertised because of special advantages available in the policy, unless either representation is true.

b. An advertisement shall not offer a Medicare supplement policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an issuer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium shall be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. The term “juxtaposition” means side by side or immediately above or below.

c. Special awards, such as a “safe driver’s award,” shall not be used in connection with advertisements of Medicare supplement insurance.

d. An invitation to inquire, which means an advertisement having as its objective the creation of a desire to inquire further about Medicare supplement insurance that is limited to a brief description of coverage, shall contain a provision in the following or substantially similar form:

“This policy has [exclusions] [limitations] [reductions of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your producer or the company [whichever is applicable].”

37.50(9) Enforcement procedures—certificate of compliance. Each issuer required to file an annual statement which is now or which hereafter becomes subject to the provisions of this chapter must file with the insurance division, with the issuer’s annual statement, a certificate of compliance executed by an authorized officer of the issuer wherein it is stated that, to the best of the authorized officer’s knowledge, information and belief, the Medicare supplement insurance advertisements that were disseminated by the issuer during the preceding statement year complied with or were made to comply in all respects with the provisions of this chapter and the laws of this state as implemented and interpreted by this chapter.

37.50(10) Filing for prior review. The commissioner may, at the commissioner’s discretion, require the filing with the insurance division, for review prior to use, of any Medicare supplement insurance advertising material.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

191—37.51(514D) Severability. If any provisions of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

[ARC 4394C, IAB 4/10/19, effective 5/15/19]

These rules are intended to implement Iowa Code chapters 507B and 514D.

**APPENDIX A
MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____**

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing This Exhibit _____
 Title _____ Telephone Number _____

Line		(a) Earned Premium ³	(b) Incurred Claims ⁴
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues ⁵		
	c. Net (for reporting purposes = 1a – 1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		

4.	Refunds Last Year (excluding interest)	
5.	Previous Since Inception (excluding interest)	
6.	Refunds Since Inception (excluding interest)	
7.	Benchmark Ratio Since Inception (see worksheet for Ratio 1)	
8.	Experienced Ratio Since Inception (Ratio 2) $\frac{\text{Total Actual Incurred Claims (line 3, col. b)}}{\text{Total Earned Prem. (line 3, col. a) – Refunds Since Inception (line 6)}}$	
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.	
10.	Tolerance Permitted (obtained from credibility table)	

¹ Individual, Group, Individual Medicare Select, or Group Medicare Select only.
² "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized Medicare supplement benefit plans.
³ Includes Modal Loadings and Fees Charged.
⁴ Excludes Active Life Reserves.
⁵ This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios."

Medicare Supplement Credibility Table

Life Years Exposed	
Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

**MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____**

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing This Exhibit _____
 Title _____ Telephone Number _____

11. Adjustment to Incurred Claims for Credibility $\text{Ratio 3} = \text{Ratio 2} + \text{Tolerance}$	
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If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
 If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a) – Refunds Since Inception (line 6)] × Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a) – Refunds Since Inception (line 6) – [Adjusted Incurred Claims (line 12) / Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

 Signature

 Name (Please type.)

 Title (Please type.)

 Date

¹ Individual, Group, Individual Medicare Select, or Group Medicare Select only.
² “SMSBP” = Standardized Medicare Supplement Benefit Plan – Use “P” for prestandardized plans.

**REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____**

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing This Exhibit _____
 Title _____ Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b) × (c)	Cumulative Loss Ratio	(d) × (e)	Factor	(b) × (g)	Cumulative Loss Ratio	(h) × (i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+ ⁶		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(1 + n)/(k + m)$: _____

- ¹ Individual, Group, Individual Medicare Select, or Group Medicare Select only.
- ² "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized Medicare supplement benefit plans.
- ³ Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.). (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
- ⁴ For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- ⁵ These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
- ⁶ To include the earned premium for all years prior to as well as the 15th year prior to the current year.

**REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____**

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing This Exhibit _____
 Title _____ Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b) × (c)	Cumulative Loss Ratio	(d) × (e)	Factor	(b) × (g)	Cumulative Loss Ratio	(h) × (i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+ ⁶		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(1 + n)/(k + m)$: _____

- ¹ Individual, Group, Individual Medicare Select, or Group Medicare Select only.
- ² "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized Medicare supplement benefit plans.
- ³ Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.). (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
- ⁴ For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- ⁵ These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes.
- ⁶ To include the earned premium for all years prior to as well as the 15th year prior to the current year.

APPENDIX B
DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies
Sold to Medicare Beneficiaries that Duplicate Medicare Benefits

1. Section 1882(d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to a Medicare beneficiary that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare benefits shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not significantly or materially vary from the attached statements in terms of language or format (using not less than 12-point type size, type-proportional spacing, bold characters, line spacing, and boxes around text).

3. State and federal law prohibits issuers from selling a Medicare supplement policy or certificate to a person that already has a Medicare supplement policy or certificate except as a replacement policy.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix B remain. An issuer may use either disclosure statement with the requisite insurance product. However, issuers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Original disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Hospice
- Other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare; or
- It pays the fixed dollar amount stated in the policy and Medicare covers the same event.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- The benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient Prescription Drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the [insert name of most recent version of *2019 Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services], available from the insurance company.
- √ For help in understanding your health insurance, contact the Senior Health Insurance Information Program (SHIIP) of the Iowa Insurance Division.

APPENDIX C
STATEMENTS AND QUESTIONS FOR APPLICATION FORMS RELATED TO DUPLICATE
OR REPLACEMENT COVERAGE

Statements

- (1) You do not need more than one Medicare supplement policy.
- (2) If you purchase this [policy or certificate], you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement [policy or certificate].
- (4) If, after purchasing this [policy or certificate], you become eligible for Medicaid, the benefits and premiums under your Medicare supplement [policy or certificate] can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement [policy or certificate] (or, if that is no longer available, a substantially equivalent [policy or certificate]) will be reinstated if requested within 90 days of losing your Medicaid eligibility. If the Medicare supplement [policy or certificate] provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your [policy or certificate] was suspended, the reinstated [policy or certificate] will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (5) If you are eligible for and have enrolled in a Medicare supplement [policy or certificate] by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement [policy or certificate] can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement [policy or certificate] under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement [policy or certificate] (or, if that is no longer available, a substantially equivalent [policy or certificate],) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement [policy or certificate] provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your [policy or certificate] was suspended, the reinstated [policy or certificate] will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Questions

If you lost or are losing other health insurance coverage and received a notice from your prior insurance company saying you were eligible for guaranteed issue of a Medicare supplement insurance [policy or certificate], or that you had certain rights to buy such a [policy or certificate], you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurance company with your application.

PLEASE ANSWER ALL QUESTIONS.

(Please mark Yes or No below with an "X".)

To the best of your knowledge,

- (1) (a) Did you turn age 65 in the last 6 months?

Yes ___ No ___

- (b) Did you enroll in Medicare Part B in the last 6 months?

Yes ___ No ___

- (c) If yes, what is the effective date? _____

- (2) Are you covered for medical assistance through the state Medicaid program?

(NOTE TO APPLICANT: If you are participating in a “Spend-Down Program” and have not met your “Share of Cost,” please answer NO to this question.)

Yes ___ No ___

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement [policy or certificate]?

Yes ___ No ___

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes ___ No ___

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave “END” blank.

START ___/___/___ END ___/___/___

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement [policy or certificate]?

Yes ___ No ___

(c) Was this your first time in this type of Medicare plan?

Yes ___ No ___

(d) Did you drop a Medicare supplement policy or certificate to enroll in this plan?

Yes ___ No ___

(4) (a) Do you have another Medicare supplement policy or certificate in force?

Yes ___ No ___

(b) If so, with what company, and what plan do you have [optional for direct mailers]?

(c) If so, do you intend to replace your current Medicare supplement policy or certificate with this [policy or certificate]?

Yes ___ No ___

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes ___ No ___

(a) If so, with what company and what kind of policy or certificate?

(b) What are your dates of coverage under the other policy or certificate?

START ___/___/___ END ___/___/___

(If you are still covered under the other policy or certificate, leave “END” blank.)

APPENDIX D

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate an existing Medicare supplement policy or certificate or Medicare Advantage policy or certificate and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement [policy or certificate] is a wise decision, you should terminate your present Medicare supplement policy or certificate or Medicare Advantage policy or certificate. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, PRODUCER [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy or certificate will not duplicate your existing Medicare supplement policy or certificate or, if applicable, Medicare Advantage policy or certificate because you intend to terminate your existing Medicare supplement policy or certificate or Medicare Advantage policy or certificate. The replacement [policy or certificate] is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage policy or certificate. Please explain reason for disenrollment. [optional only for direct mailers]
- Other. (Please specify.) _____

1. **Note:** If the issuer of the Medicare supplement policy or certificate being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new [policy or certificate], whereas a similar claim might have been payable under your present policy or certificate.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurance company will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy or certificate (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy or certificate.

3. If you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy or certificate until you have received your new [policy or certificate] and are sure that you want to keep it.

(Signature of Producer, Broker or Other Representative)*
[Typed Name and Address of Issuer, and of Producer or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

APPENDIX E
OUTLINE OF COVERAGE: BENEFIT CHARTS

[Any amount in brackets in this Appendix E shall be changed to coincide with any change in amount made by the Secretary of the U.S. Department of Health and Human Services.]

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates On or After June 1, 2010

This chart shows the benefits included in each of the standardized Medicare Supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$[5560]; paid at 100% after limit reached	Out-of-pocket limit \$[2780]; paid at 100% after limit reached		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2300] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$[2300]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the

policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION [Boldface Type]

We, [insert issuer's name], can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured individual, include information specifying when premiums will change.]

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for producers:]

Neither [insert company's name] nor its producers are connected with Medicare.

[for direct response:]

[Insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare and You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page a chart showing the services, Medicare payments, plan payments and insured payments, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this Appendix E: Outline of Coverage. An issuer may use additional benefit plan descriptions on these charts pursuant to paragraph 37.8(1) "c."]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

Benefit Chart of Medicare Supplement Plans Sold On or After January 1, 2020

This chart shows the benefits included in each of the standardized Medicare supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ Copays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2019] ²					[\$5560] ²	[\$2780] ²				

¹Plans F and G also have high deductible options which require first paying the plans' deductibles of [\$2300] before the plans begin to pay. Once the plans' deductibles are met, the plans pay 100% of covered services for the rest of the calendar year. High deductible Plan G does not cover the Medicare Part B deductible. However, high deductible Plans F and G count your payments of the Medicare Part B deductible toward meeting the plan deductibles.

²Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limits.

³Plan N pays 100% of the Medicare Part B coinsurance, except for copayments of up to \$20 for some office visits and up to \$50 copayments for emergency room visits that do not result in inpatient admissions.

PLAN A
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$0	\$[1364] (Part A deductible)
61st through 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$[170.50] a day	\$0	Up to \$[170.50] a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurance company stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's basic core benefits ("basic core benefits" are the equivalent of what is provided under Medicare Part A). During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN A
MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

* Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Medicare Part B deductible will have been met for the calendar year.

MEDICARE PLAN B
MEDICARE PART A—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61st through 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$[170.50] a day	\$0	Up to \$[170.50] a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurance company stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's basic core benefits ("basic core benefits" are the equivalent of what is provided under Medicare Part A). During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN B
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

* Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN C
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61st through 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$[170.50] a day	Up to \$[170.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurance company stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's basic core benefits ("basic core benefits" are the equivalent of what is provided under Medicare Part A). During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN C
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	[\$185] (Part B deductible)	\$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[185] of Medicare-Approved Amounts*	\$0	[\$185] (Part B deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN C
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	[\$185] (Part B deductible)	\$0
Remainder of Medicare-Approved Amounts*	80%	20%	\$0

* Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PLAN C
OTHER BENEFITS—NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN D
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61st through 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$[170.50] a day	Up to \$[170.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurance company stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's basic core benefits ("basic core benefits" are the equivalent of what is provided under Medicare Part A). During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN D
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN D
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

* Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PLAN D
OTHER BENEFITS—NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61st through 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$[170.50] a day	Up to \$[170.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$[2300] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2300]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurance company stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's basic core ("basic core benefits" are the equivalent of what is provided under Medicare Part A). During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	[\$185] (Part B deductible)	\$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[185] of Medicare-Approved Amounts*	\$0	[\$185] (Part B deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

[** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$[2300] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2300]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

**PLAN F or HIGH DEDUCTIBLE PLAN F
PARTS A & B**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	[\$185] (Part B deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0

**PLAN F or HIGH DEDUCTIBLE PLAN F
OTHER BENEFITS—NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

[** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$[2300] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2300]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

**PLAN G or HIGH DEDUCTIBLE PLAN G
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61st through 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$[170.50] a day	Up to \$[170.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [\$2300] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [\$2300]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's basic core benefits ("basic core benefits" are the equivalent of what is provided under Medicare Part A). During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN G or HIGH DEDUCTIBLE PLAN G
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	\$0	\$[185] (Unless Part B deductible has been met)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	100%	0%
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[185] of Medicare-Approved Amounts*	\$0	\$0	\$[185] (Unless Part B deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$[2300] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$[2300]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan’s separate foreign travel emergency deductible.]

**PLAN G or HIGH DEDUCTIBLE PLAN G
PARTS A & B**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Unless Part B deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

**PLAN G or HIGH DEDUCTIBLE PLAN G
OTHER BENEFITS—NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$[2300] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$[2300]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan’s separate foreign travel emergency deductible.]

PLAN K

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$(682) (50% of Part A deductible)	\$(682) (50% of Part A deductible)♦
61st through 90th day	All but \$[341] a day	\$(341) a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$(682) a day	\$(682) a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$[170.50] a day	Up to \$[85.25] a day	Up to \$[85.25] a day♦
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	50%	50%♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance♦

* You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of \$[5560] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"), and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurance company stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's basic core benefits ("basic core benefits" are the equivalent of what is provided under Medicare Part A). During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K
 MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$[185] of Medicare-Approved Amounts****	\$0	\$0	\$[185] (Part B deductible)****♦
Preventive Benefits for Medicare-Covered Services	Generally 80% or more of Medicare- Approved Amounts	Remainder of Medicare-Approved Amounts	All costs above Medicare-Approved Amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$[5560])*
BLOOD			
First 3 pints	\$0	50%	50%♦
Next \$[185] of Medicare-Approved Amounts****	\$0	\$0	\$[185] (Part B deductible)****♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of \$[5560] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”), and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**** Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN K
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[185] of Medicare-Approved Amounts*****	\$0	\$0	\$[185] (Part B deductible)♦
Remainder of Medicare-Approved Amounts	80%	10%	10%♦

Medicare benefits are subject to change. Please consult the latest [*Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services].

* You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of \$[5560] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”), and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

***** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[5560] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”), and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L
 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[1364] All but \$[341] a day All but \$[682] a day \$0 \$0	\$[1023] (75% of Part A deductible) \$[341] a day \$[682] a day 100% of Medicare eligible expenses \$0	\$[341] (25% of Part A deductible)♦ \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[170.50] a day \$0	\$0 Up to \$[127.88] a day (75% of Part A Coinsurance) \$0	\$0 Up to \$[42.63] a day (25% of Part A Coinsurance)♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	75% \$0	25%♦ \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance♦

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of \$[2780] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"), and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurance company stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's basic core benefits ("basic core benefits" are the equivalent of what is provided under Medicare Part A). During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L
 MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$[185] of Medicare-Approved Amounts****	\$0	\$0	\$[185] (Part B deductible)****◆
Preventive Benefits for Medicare-Covered Services	Generally 75% or more of Medicare- Approved Amounts	Remainder of Medicare-Approved Amounts	All costs above Medicare-Approved Amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%◆
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$[2780])*
BLOOD			
First 3 pints	\$0	75%	25%◆
Next \$[185] of Medicare-Approved Amounts****	\$0	\$0	\$[185] (Part B deductible)◆
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of \$[2780] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”), and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**** Once you have been billed \$[185] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN L
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[185] of Medicare-Approved Amounts****	\$0	\$0	\$[185] (Part B deductible)♦
Remainder of Medicare-Approved Amounts	80%	15%	5%♦

Medicare benefits are subject to change. Please consult the latest [*Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, issued by Centers for Medicare and Medicaid Services].

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of \$[2780] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”), and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**** Once you have been billed \$[185] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN M
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[1364] All but \$[341] a day All but \$[682] a day \$0 \$0	\$[682] (50% of Part A deductible) \$[341] a day \$[682] a day 100% of Medicare eligible expenses \$0	\$[682] (50% of Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[170.50] a day \$0	\$0 Up to \$[170.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurance company stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's basic core benefits ("basic core benefits" are the equivalent of what is provided under Medicare Part A). During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M
 MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	0%
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[185] of Medicare-Approved Amounts*	\$0	\$0	[\$185] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PLAN M
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment	\$0	\$0	[\$185] (Part B deductible)
First [\$185] of Medicare-Approved Amounts*			
Remainder of Medicare-Approved Amounts	80%	20%	\$0

* Once you have been billed [\$185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PLAN M
OTHER BENEFITS—NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN N
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61st through 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$[170.50] a day	Up to \$[170.50] a day	\$0**
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurance company stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's basic core benefits ("basic core benefits" are the equivalent of what is provided under Medicare Part A). During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[185] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured individual is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$[185] (Part B deductible) Up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured individual is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[185] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[185] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PLAN N
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment	\$0	\$0	[\$185] (Part B deductible)
First \$[185] of Medicare-Approved Amounts*			
Remainder of Medicare-Approved Amounts	80%	20%	\$0

* Once you have been billed \$[185] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PLAN N
OTHER BENEFITS—NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

APPENDIX F
FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES
Pursuant to Iowa Administrative Code rule 191—37.32(514D)

Company Name: _____
 Address: _____

 Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by covered individual.

Policy and Certificate #	Date of Issuance

Signature

Name and Title (please type)

Date

- [Filed 11/5/81, Notice 9/2/81—published 11/25/81, effective 12/31/81¹
- [Editorially transferred from [510] to [191] IAC Supp. 10/22/86; see IAB 7/30/86]
- [Filed emergency 12/9/88—published 12/28/88, effective 12/31/88]
- [Filed 8/31/90, Notice 7/25/90—published 9/19/90, effective 12/1/90]
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- [Filed emergency 8/18/98—published 9/9/98, effective 8/18/98]
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- [Filed emergency 1/5/01—published 1/24/01, effective 1/5/01]
- [Filed 11/21/01, Notice 10/17/01—published 12/12/01, effective 1/16/02]
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- [Filed ARC 7964B (Notice ARC 7795B, IAB 5/20/09), IAB 7/15/09, effective 8/19/09]
- [Filed ARC 3682C (Notice ARC 3571C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

[Filed ARC 4394C (Notice ARC 4282C, IAB 2/13/19), IAB 4/10/19, effective 5/15/19]

¹ Effective date of 12/31/81 delayed 70 days by Administrative Rules Review Committee.